Delegation to Wellington
The UN and WHO Pandemic Treaties
nzdelegationwhotreaties@gmail.com

6 November 2023

Attorney-General
Crown Law Office
Parliamentary Counsel Office
Wellington

By email: D.Parker@ministers.govt.nz

Attention: Hon David Parker

Dear Hon Mr Parker

An Open Letter from the Delegation To Wellington
UN and WHO New and Amended Pandemic Treaties

1. We write as a group of concerned New Zealanders. We raise with you concerns we have about four treaties and accords of international significance (**Treaties**) that have either been adopted or are currently being drafted or amended by the United Nations (**UN**) and the World Health Organisation (**WHO**) following the recent public health response to the Covid-19 pandemic[1].

2. What is proposed in these Treaties, if tacitly accepted by New Zealand, will mean:

   2.1 we are bound without reservation to significant obligations;

   2.2 we will forfeit the right to make decisions as a country with respect to "all risks with a potential to impact public health";

   2.3 we will be required to amend and implement domestic legislation in accordance with the new Treaties.

3. The four Treaties are at various stages of completion, the:

   3.1 WHO's Article 59 amendments to the International Health Regulations (**IHRAs**) (reducing timeframes) (**Article 59 IHRAs**), which has already been

[1] See **Schedule 1** to this letter.

adopted at the Seventy-fourth World Health Assembly (WHA) held May 2022. They require express rejection by New Zealand by **1 December 2023**, otherwise silence is acceptance and the amendments become binding on New Zealand. We expand on the status of the Article 59 IHRAs in **Schedule 2**, paragraph 2 and 3 to this letter.

3.2 UN's Political Declaration on Pandemic Prevention, Preparedness and Response Manifesto- Zero Draft (**UN PPPR Declaration**) has been tentatively adopted on 20 September 2023 subject to convening of a full General Assembly. There is nothing for New Zealand to do here.

3.3 WHO's 307 IHRAs are currently being drafted by the Working Group and are required to be delivered to the Director General, WHO, by mid January 2024 in accordance with Article 55 of the IHRs for adoption at the WHA end May 2024 (subject to the legal opinion received set out in **Schedule 2**, page 7, paragraph 6).

3.4 WHO's entirely new pandemic 'treaty' the new WHO CA+ which is a "Proposal for negotiating text of the WHO Pandemic Agreement".

More details on the four Treaties, are set out in **Schedule 2** to this letter.

4. What we seek from the office of the Attorney General on or before **24 November 2023** (bearing in mind the other dates and deadlines referenced in this letter):

4.1 Acknowledge receipt of this letter and confirm whether:

a) You and your office are aware of the four Treaties; and whether

b) You are considering how they will impact on the laws of New Zealand, including Treaty of Waitangi obligations, as well as all international instruments we are a party to.

4.2 Respond in writing to the following questions:

a) What preparatory work has your office undertaken in respect to the four Treaties, which have the potential to adversely impact on the human rights of New Zealanders?

b) If New Zealand were to tacitly accept the Treaties, what will be the effect on the operation of New Zealand sovereignty, domestic laws, international law, human rights and Treaty of Waitangi obligations?

4.3 Take the following steps:

a) Issue a direction to Cabinet to consider the Article 59 IHRAs as against the 307 IHRAs, the WHO CA+ and the UN PPPR Declaration. If there is insufficient time for Cabinet to consider these before the 1 December 2023 date for rejection or reservation, then reject or reserve New Zealand's position on the Article 59 IHRAs until it has had time to consider these. The assessed legal ramifications are summarised in the article attached as **Schedule 3** to this letter.

b) Inform the new government of the four Treaty documents, the directive you have issued at 4.3a) immediately above, and that you are considering the legitimate concerns raised in this letter.

5. We have prepared the following information set out in the schedules here to assist you and your office.

6. Further, we have sent a similar letter to the Human Rights Commissioner, **attached** here for your information.

We would be more than willing to meet with your office, otherwise and in the meantime we look forward to hearing from you as soon as possible.

Yours sincerely
For and on behalf of The Delegation To Wellington:

Katie Ashby-Koppens
Qualified Barrister and Solicitor of High Court of New Zealand

The Delegation To Wellington:
Dr Simon Thornley, Faculty of Medical and Health Sciences, Epidemiology and Biostatistics, University of Auckland
Martin Lally (Director, and former Associate Professor in Finance at Victoria University of Wellington)
Dr Alison Goodwin (President, New Zealand Medical Professionals' Society)
Dr Anne O'Rielly (Vice-President, New Zealand Medical Professionals' Society)
Dr Cindy de Villiers (New Zealand Doctors Speaking Out with Science)
Aku Huia Kaimanawa (Midwives Collective)

Jodie Brunning (MA Sociology, Physicians and Scientists for Global Responsibility (PSGR.org))
Katie Ashby-Koppens (Qualified Barrister and Solicitor of New Zealand)
Keri Molloy (Journalist)
Lynda Wharton (The Health Forum NZ)

Schedule 1 – Further comments on the recent public health response to the Covid-19 pandemic from a public law perspective

1. Fairness is a guiding principle of public law in New Zealand. However, the binding nature of the Amendments may result in the taking of arbitrary power that is antithetical to a constitutional monarchy. Law must conform to minimum standards of justice. Another word for fairness – is natural justice. The rule of law is based on the reconciling of state power with personal autonomy and liberty – and it's based on the factual setting in which law or policy is engaged. A pandemic will differ in the health impact by country, by age, by socio-economic status, and by health status.

2. The COVID-19 pandemic response saw a jettisoning of traditional public health principles that would be engaged in the management of pandemics. These are relevant to the IHRA amendment processes as the processes and policies that were implemented for COVID-19 serves as a precedent for future events.

3. The 2009 version of the WHO's Pandemic Alert Phases removed an association with severe risk. This enabled COVID-19 to be declared a pandemic without the majority of the population being at risk of hospitalisation and death. A high-risk event was not distinguished from an event of mild disease. (Abeysinghe 2013).

4. Fundamental principles that guide public health management were strangely ignored during the COVID-19 pandemic. Public health concerns the weighting of costs and benefits, and it is necessarily a local endeavour as particular sub-populations will be more or less at risk from different interventions. For example, the 2019 recommendations of pandemic influenza management strongly advised against measures such as border closures, or quarantine or restriction of healthy people. In place, modelling was used which also ignored known facts, such as the potential for natural immunity to stem infectivity and the potential for new viral variants to be more transmissible but less harmful.

5. The IHRA's are taken at a time when a decline in country-based core funding to the WHO has occurred, diverting the organization from its traditional public health funds. In 2021-2022 $6.4 billion of just under $8 billion in expenditure was due to earmarked funds. There has been a concurrent growth of international bodies parallel to the WHO whose focus is not on traditional public health activities, but on technologies.(Bell 2023) Cross-talk and funding between these organisations result in donor influence that may be stronger than the influence of individual member nations.

Schedule 2 – Background and further information and documents pertaining to the UN and WHO New and Amended Pandemic Treaties

1. UN's PPPR Declaration

The **UN's PPPR Declaration** was only tentatively adopted by the President of the General Assembly at the UN High-Level Meeting on 20 September 2023 after eleven (11) nations raised concerns about the lack of 'true and meaningful' engagement in the negotiations of the declaration and opposing the attempt to adopt the declaration at a high level meeting, instead of the full assembly, which is required by the relevant resolution.

Amongst other things, the UN PPPR Declaration identifies the requirement for US$30 billion for pandemic preparedness. By way of comparison, the WHO's current 2 yearly budget is US$11 billion.

The UN PPPR Declaration also sets out the requirement for any amendments to the 2005 International Health Regulations (**IHRs**) and the creation of a new Pandemic Treaty (the **WHO CA+**) by the Seventy-seventh World Health Assembly scheduled for the end of May 2024 (OP44 UN PPPR Declaration) and also confirmed in the WHO Decision WHA75(9).

2. The WHO's proposed amendments to the 2005 International Health Regulations (IHRAs) - are in two parts (2.1 and 2.2):

2.1 **Article 59 IHRAs** - This treaty proposes reducing the timing for rejection or implementation for any future proposed IHRAs (from 18 to 10 months, and 24 to 12 months respectively).

The Article 59 IHRAs were adopted by the WHA on 27 May 2022 – pursuant to Article 59 of IHRs the there is 18 months to expressly reject or reserve these proposed amendments by **1 December 2023**, otherwise the timeframes will become much shorter for assessment, rejection and implementation of any future amendments, relevantly the 307 IHRAs described in 2.2 immediately below. We also expand upon the Article 59 IHRAs in paragraph 3 of this schedule.

2.2 **307 IHRAs** are being worked on by the IHR Working Group at present. The 307 IHRAs propose significant changes to the 2005 IHRs including:

a) changing standing recommendations from non-binding to binding (Article 1);

b) changing the Scope and Purpose from one where the WHO advises on actual 'public health risk[s]' to the WHO giving binding directives on "all risks with a potential to impact public health" – ie not just pandemics, and could include climate events (Articles 1 and 2);

c) removing the Principle implementation of the Regulations from one focussed on the "full respect for dignity, human rights and fundamental freedoms of persons" to one "based on the principles of equity, inclusivity, coherence and in the common but differentiated responsibilities of the State Parties, taking into consideration their social and economic development" (Article 3);

d) requiring significant changes to our domestic legislation (eg Articles 5 and 55).

This is by no way a complete list. Further examples and analysis of the provisions are available here.

Pursuant to Article 55 of the IHRs, the text of any amendments is to be provided at least four months before the World Health Assembly meets so as to give the member states sufficient time to consider before they meet to vote on the adoption of the amendments (or otherwise). That is, the 307 IHRAs are to be submitted to the Director General of the WHO by mid-January 2024 for anticipated adoption at the Seventy-seventh WHA at the end of May 2024 as per the UN PPPR Declaration (OP44) and also confirmed in the relevant WHO Decision WHA75(9).

At the 2-6 October 2023 meeting of the Working Group of the IHRAs, the Working Group indicated it will not be able to meet the January 2024 delivery date (of mid January 2024) and has sought advice exempting the Working Group from complying with this timeframe and obligations under Article 55. Advice supplied by Stephen Solomon (WHO Secretariat legal counsel) at 27:00 or transcribed in **Schedule 3** for your convenience has set out an approach that would allow them to continue to work on the IHRAs up until the Seventy-seventh World Health Assembly.

Note this purported legal advice is not only wrong, it is in flagrant disregard and contravention of the Regulations themselves and the WHO Decision WHA75(9) which clearly set out that Article 55 of the IHRs applied to the IHRAs.

If the Working Group will not have the text of the 307 IHRAs finalised and available four months in advance of the Seventy-seventh meeting of the World Health Assembly, then there is no way New Zealand can reasonable acquiesce to shorter timeframes proposed under the Article 59 IHRAs.

2.3 The WHO's drafting of an entirely new **WHO CA+** is currently being worked on by the Intergovernmental Negotiating Body.

The WHO CA+ is it is a "Proposal for negotiating text of the WHO Pandemic Agreement", ie its an agreement to agree, or a heads of agreement – it is not actually a Treaty which New Zealand can review and draw conclusions from as to its suitability for New Zealand.

The WHO CA+ also sets out significant new requirements under what might best be considered a trade agreement for pharmaceutical products and medical and surveillance technology.

The WHO CA+ is also anticipated to be adopted at the Seventy-seventh WHA at the end of May 2024 as per the UN PPPR Declaration (OP44).

3. Article 59 IHRAs – future timeframes drastically reduced unless the Article 59 IHRAs expressly rejected

Current status of the Article 59 IHRAs:

On 19 October 2023, the Ministry of Health proactively released Cabinet material and briefings: Minor Amendments to the International Health Regulations 2005 Approval for Binding Action ministerial decision-making documents: which proposes New Zealand be bound to the minor administrative amendments proposed in the Article 59 IHRAs, and that tacit agreement means no action needs to be taken (and the amendments will become binding)

We are concerned that Cabinet only considered the Article 59 IHRAs on their own, without reference to any of the other three Treaty documents (two of which we appreciate are currently being worked on, but are all at stages of significant advancement, so as to be informative to whether Cabinet tacitly agrees to the shortened timeframes).

Further, we note Cabinet's dismissed the Te Aka Whai Ora's (Maori Health Authority) concerns[2] about the shorter time frames under the Article 59 IHRAs on the basis that the Authority can start reviewing the 307 IHRAs in advance. However, that solution is not possible, given the extension the IHR Working Group has received to continue to negotiate the 307 IHRAs up until the date they will be considered by the Assembly for adoption.

[2] Cabinet Paper, Document 2, Page 4, paragraphs 21-23.

Why we are concerned with the Article 59 IHRAs:

The UN PPPR Declaration (OP44) states that the WHO CA+ is "an ambitious legally binding convention" adopted under "Article 19 of the Constitution of the World Health Organization"; and the Article 59 IHRAs and the 307 IHRAs are one of the "other initiatives to support the central endeavour". Where the Treaties' legally binding ambition are realised, New Zealand will have significantly reduced latitude in managing epidemic infections under WHO jurisdiction (which at this stage is no longer an actual "public health risk" but "all risks with a potential to impact public health" (see Article 2, 307 IHRAs)).

The Treaties are a culmination of the UN PPPR Declaration. The significant limitations on timeframes under the Article 59 IHRAs will constrain the time available for our government to properly consider, reject and/or implement (at least) future IHRAs (ie the 307 IHRAs). The shortened timeline will not provide sufficient time for fulsome consideration of the impact and breadth of the IHRAs by New Zealand. Nor will the compressed timeframe allow for proper consultation with New Zealanders in accordance with our democracy.

The question has to be – what is the rush, and also how and why does this benefit New Zealand?

These timeframes in the Article 59 IHRAs need to be expressly rejected as the proposed reductions in time means that New Zealand will only have 10 months to consider the significant legal ramifications on our domestic legislation that the 307 IHRAs will require. Additionally within a similar timeline, New Zealand needs to consider in parallel the WHO CA+ and its implications.

We reiterate the Te Aka Whai Ora's concerns with the reduction in timeframes proposed under Article 59 IHRAs as set out under section 3 immediately above.

Further, given the 307 IHRAs will continue to be negotiated up until the Seventy-seventh World Health Assembly in May 2024, then we strongly recommend that the Article 59 IHRs be rejected pursuant to Article 59 and 61, or at the least reservations made pursuant to Article 62 to allow opportunity to consider the impacts of the future IHRAs, such as the 307 IHRAs. The Working Group to the 307 IHRAs need more time, let's all give ourselves as much time available to review these wide sweeping reforms of international significance.

4. The legally binding aspects of the WHO's 307 IHRAs and the WHO CA+

There is a clear implication in the Treaties that if not actively responded to, New Zealand will have to amend vast arrays of its domestic legislation, to comply with very significant amendments to the 2005 IHRs and the new WHO CA+, such as the:

4.1 legally binding nature (Article 1 of the 307 IHRAs; paragraph OP44 of the WHO CA+);

4.2 express amendment to laws (Articles new 13A(3), 43, 44, and 45 of the 307 IHRAs);

4.3 implementation of new legislation to indemnify pharmaceutical companies and limit their liability with respect to vaccine injuries as well as establish "no-fault vaccine injury compensation mechanisms" (Article 15 WHO CA+).

These are by no means a complete list of the Articles or amendments that could impact New Zealand domestic laws as set out in the UN PPPR Declaration, 307 IHRAs and the WHO CA+.

5. The very real consequences of the legally binding aspects of the WHO's 307 IHRAs and the WHO CA+

When similar issues set out in this letter are raised, we are regularly reassured that:

> *"While the exact form of the instrument is yet to be determined, if Member States agree to proceed with a legally binding instrument (for example, a treaty) standard New Zealand treaty-making processes, including Cabinet approval and parliamentary treaty examination, will be required before New Zealand could become party to the treaty.*
>
> *New Zealand government representatives are participating in negotiations in both the INB and WHR. Any decision to become party to a new treaty will be decided by the government once negotiations are concluded and would be subject to New Zealand's treaty-making processes, including Cabinet approval, parliamentary treaty examination, and the passing of legislation if required."*

We appreciate and understand the position being advanced. However, the reassurances are, with respect, disingenuous. By acquiescing to the 307 IHRAs and/or becoming a party to the WHO CA+, New Zealand will be promising to implement what it has agreed to in those international instruments. By acquiescing

to the Article 59 IHRAs New Zealand will severely constrain the time able to be given to undertake its standard treaty-making process.

It is important to acknowledge that in giving those promises New Zealand is pledging to the UN and the WHO, as well as the international community, its intention to ratify and enshrine those instruments in our domestic law. It is also important to ask the question; what would be the consequences of our failure to do so?

Further, when making new laws, or amending existing ones, Parliament (both current and future) have a positive onus to take into account all international covenants, treaties and instruments New Zealand is a party to. If New Zealand is a party to the 307 IHRAs and the WHO CA+, could Parliament selectively choose to legislate the international instruments articles it has agreed to and ignore the remainder?

This is why these Treaties cause concern, and why these concerns cannot be dismissed.

The 2005 IHRs, to which New Zealand is already a party and which are legally binding, at Article 59, sub 3 makes clear, that:

> *"If **a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations** within the period set out in paragraph 2 of this Article, **that State shall submit** within the period specified in paragraph 1 of this Article **a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations for that State Party.**"* (emphasis added)

The words could not be more clear. If this is the case, then 10 months to consider any future IHRAs such as the 307 IHRAs, and a further 12 months to implement them, will be impossible and consequently could result in legitimate consequences such as geopolitical sanctions and other international pressures for failure to comply and/or implement. Alternatively the constrained time period might impel New Zealand to consideration under Urgency curtailing proper examination and public consultation and agreement.

6. New Zealand’s human rights

These Treaties shall also impact New Zealand's human rights policy agenda. Examples of those impacts have been outlined in the letter addressed to the Human Rights Commissioner (**attached**).

Schedule 3 – ARTICLE:

The rejection, or reservation, by our governments to the WHO's proposed Article 59 amendments to the International Health Regulations is not a big deal – it's a bigger deal if they don't!

The Article 59 IHRAs have to be reserved or rejected by every member state to ensure the WHO follows its own rules! It will also help the Working Group, who are struggling to meet the mid January 2024 delivery date.

The rejection or reservation is not a big deal, it will simply give the member state the time to which it is entitled, to consider the substantial amendments that are coming!

The Article 59 amendments to the International Health Regulations (IHRAs) need to be actively rejected or reserved by each of the 194 member states by 1 December 2023, otherwise silence is acceptance and the amendments become binding on every member state that doesn't actively reject or reserve.

The Article 59 IHRAs seem minor in nature, they reduce the time frames from 18 months to 10 months for any rejection of future amendments, and from 24 months to 12 months for any implementation.

They need to be rejected or reserved because the WHO is ignoring its own rules to ram through the proposed amendments to the International Health Regulations (IHRAs), which it hasn't been able to finalise even in the 20 months the Working Group has had available to do so.

Both the Australian and New Zealand governments consider the Article 59 IHRAs are minor in nature: nothing to see here – the UN and WHO's Pandemic Treaties are a good thing - in everyone's best interests, while refusing to engage with the substance of the other treaty documents: the UN's Pandemic Preparedness Declaration, the 307 amendments to the IHRs and the recently updated and circulated WHO CA+.

Ordinarily, those shorter timeframes proposed in the Article 59 IHRAs might not be a tough ask for any government to consider, especially when the IHRs have always meant that the WHO is an organisation that gave advice (ie the Regulations were non-binding). However, what is proposed in the other WHO Treaty documents is more than any government can reasonably consider in 10 months, let alone the current 18 months it has available to it under the IHRs. Further hampering the timeframe for any review of the Treaty documents, the Regulations will be BINDING on each member state who doesn't expressly reject or reserve them. The 18 month time frames are already ambitious, in 10 months they will be impossible for our governments to properly consider the ramifications on our domestic legislation and obligations.

The shorter time frames might also be ok if the WHO was complying with the timeframes set out in their own rules (Article 55, below) meaning that any amendments are completed and circulated 4 months in advance of it being adopted at the World Health Assembly. That 4 month rule gives member states the opportunity to consider any amendments prior to them being considered for adoption at the World Health Assembly (which only meet once a year).

The 307 IHRAs presently being worked up by the Working Group (of which NZ's own Dr Bloomfield is a Co-chair), are required to be finalised and presented to the Director General of the WHO by mid January 2024 if they are to be considered by the 194 member states in time for adoption at the Seventy-seventh World Health Assembly scheduled in May 2024 (in compliance with Article 55 and confirmed in the U.N.'s Pandemic Preparedness Declaration (see OP 44)).

However, at the last meeting of the Working Group of the IHRAs, the Working Group confirmed that the 307 IHRAs won't be finalised and ready to provide to the IHR Review Committee and Director General by mid January 2024 (in compliance with the 4 month rule).

Consequently, advice was sought by the Working Group, from the WHO's lawyer about how the Working Group could get around the 4 month rule and continue to work on the 307 IHRAs up until May 2024, when the World Health Assembly next convenes to consider adoption of the rules (PS adoption by the WHA is likely *a fait accompli*).

The WHO's lawyer had such advice to hand: the 4 month rule to have the 307 IHRAs finalised in time for the member states to consider, doesn't apply to the Working Group is a subdivision of the World Health Assembly.

Stephen Solomon (WHO Secretariat legal counsel) had this to say at 27:00:

> *Article 55 of the IHR, including this four month requirement, has never been applied to amendments submitted collectively by a sub-division of the Health Assembly, which is exactly what the WGIHR is.*
>
> *The WGIHR is a subdivision of the Health Assembly under rule 41 [40?] of the Rules of Procedure of the Health Assembly.*
>
> *Thus, there are no precedents to rely on with respect to the manner in which the four month requirement set out in Article 55 should be satisfied.*
>
> *That is to say, Article 55 has been applied to amendments proposed by a state party or by the Director-General, but never by a subdivision of the Health Assembly.*

Accordingly, an option for consideration by the Working Group, would be for the Director-General to communicate in January 2023 [2024?] the following documents to all states parties:

First, the proposed amendments as originally submitted by member states and already communicated by the Secretariat to all states parties by email, and

Second, the proposed amendments as they might be shown on the screen at the closure of WGIHR/6.

This approach would allow work to continue in the WGIHR, if necessary, up until the 77th Health Assembly itself, recognizing the importance of complementarity with the INB process which, as we know, is mandated to work up until the 77th WHA.

In addition to that, the Working Group may consider requesting the Secretariat to include, in the January communication from the Director-General, a clarification according to which the amendments from the final session of the WGIHR, which could be, conceivably, as late as May, 2024, if necessary, would allow these final results of the May, of such a session, to be formally submitted to the 77th World Health Assembly.

A note on this deadline of the 77th World Health Assembly. If the deadline is not met, the WGIHR would be expected to report to the Health Assembly in May 2024 that agreement could not be reached on the proposed amendments.

This deadline cannot be changed as it was set out in decision WHA75/9 [(Decision)].

This approach just outlined for your consideration would fulfill the four month requirement in its purpose as proscribed by Article 55 of the IHR, while at the same time allowing the Working Group to continue its consideration and negotiation of the proposed amendments, including possible modifications to the package that would be communicated to the States Parties.

Should this approach be considered satisfactory, the Working Group may wish to consider reflecting it in the report of this session of the WGIHR.

(emphasis added)

So the deadline in the Decision can't be changed, but the deadline specified in the Regulations can be?

Let's be clear, the order of precedence is that Regulations come before decisions, that is Decisions are much easier to amend than Regulations, unless of course you ignore the Regulations.

This is nothing but Double Dutch, legal contortionism at its best, and this is why:

The Article 55 of the Regulations on amendments to the IHRs state:

1. *Amendments to these Regulations may be proposed by any State Party or by the Director-General. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.*
2. *The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration.*
3. *Amendments to these Regulations adopted by the Health Assembly pursuant to this Article shall come into force for all States Parties on the same terms, and subject to the same rights and obligations, as provided for in Article 22 of the Constitution of WHO and Articles 59 to 64 of these Regulations.*

Applying the words of the Article 59, the 307 IHRAs are:

1. amendments to be proposed by the Director General – as per 2(e) of the Decision, which specified "*the IHR Review Committee submit its report to the Director-General no later than 15 January 2023, with the Director-General communicating it without delay to the WGIHR"*
   - therefore satisfying Regulation Article 55 sub 1;
2. the Director General is required to submit any proposed amendments four months before the Health Assembly at which it is proposed for consideration - therefore satisfying Regulation Article 55 sub 2;
3. if adopted by the World Health Assembly, then as per Regulation Article 55 sub 3, the 307 IHRAs come into force subject to the timeframe requirements for rejection or reservation – ie the Article 59 IHRAs – pretty circular isn't it!

But wait, you don't have to trust my opinion on this, the Decision actually refers to the Working Group complying with the Article 55 timeframe, see 2(f) of the Decision, which states:

> "*to request the WGIHR to establish a programme of work, consistent with decision EB150(3), and taking into consideration the report of the IHR Review Committee, to propose a package of targeted amendments, for consideration by the Seventy-seventh World Health Assembly, in accordance with Article 55 of the International Health Regulations (2005);"*

The WHO's lawyer is making things up in breach of both the Regulations and the Decision.

The Article 59 IHRAs simply reduce the time frames for a member state to reject and implement.

If the Working Group needs more time on the IHRAs then that can be granted by amending the

Decision, then it has to be done by member states rejecting the Article 59 IHRAs, which means the old rules or 18 months to consider any amendments remains in place.

All this rejection does is give a member state the time to which it is entitled under the Regulations, to consider fully the sweeping changes proposed in the 307 IHRAs and the WHO CA+.

Our governments can buy the time they need to review the Treaties on our behalf, and in our interests, by simply rejecting or reserving their positions on the Article 59 IHRs and await the 307 IHRAs, which the Working Group needs more time to finalise.

The other benefit to this is that the various commissions and inquiries can be finalised, the outcomes of which can be aspects that best inform our governments.

Katie Ashby-Koppens
Qualified Barrister and Solicitor of the
High Court of New Zealand
Lawyer, NSW

Katie has had the opportunity to present to the US and Australian governments on the UN and WHO Pandemic Treaties. Katie's particular focus is on the impacts and effects of these Treaty documents on the member states of US, AU and NZ and their citizens.

Annexure: attached letter to Human Rights Commission

Delegation to Wellington
The UN and WHO Pandemic Treaties
nzdelegationwhotreaties@gmail.com

6 November 2023

Attorney-General
Crown Law Office
Parliamentary Counsel Office
Wellington

By email: D.Parker@ministers.govt.nz

Attention: Hon David Parker

Dear Hon Mr Parker

An Open Letter from the Delegation To Wellington
UN and WHO New and Amended Pandemic Treaties

1. We write as a group of concerned New Zealanders. We raise with you concerns we have about four treaties and accords of international significance (**Treaties**) that have either been adopted or are currently being drafted or amended by the United Nations (**UN**) and the World Health Organisation (**WHO**) following the recent public health response to the Covid-19 pandemic[1].

2. What is proposed in these Treaties, if tacitly accepted by New Zealand, will mean:

   2.1 we are bound without reservation to significant obligations;

   2.2 we will forfeit the right to make decisions as a country with respect to "all risks with a potential to impact public health";

   2.3 we will be required to amend and implement domestic legislation in accordance with the new Treaties.

3. The four Treaties are at various stages of completion, the:

   3.1 WHO's Article 59 amendments to the International Health Regulations (**IHRAs**) (reducing timeframes) (**Article 59 IHRAs**), which has already been

[1] See **Schedule 1** to this letter.

adopted at the Seventy-fourth World Health Assembly (WHA) held May 2022. They require express rejection by New Zealand by **1 December 2023**, otherwise silence is acceptance and the amendments become binding on New Zealand. We expand on the status of the Article 59 IHRAs in **Schedule 2**, paragraph 2 and 3 to this letter.

3.2 UN's Political Declaration on Pandemic Prevention, Preparedness and Response Manifesto- Zero Draft (**UN PPPR Declaration**) has been tentatively adopted on 20 September 2023 subject to convening of a full General Assembly. There is nothing for New Zealand to do here.

3.3 WHO's 307 IHRAs are currently being drafted by the Working Group and are required to be delivered to the Director General, WHO, by mid January 2024 in accordance with Article 55 of the IHRs for adoption at the WHA end May 2024 (subject to the legal opinion received set out in **Schedule 2**, page 7, paragraph 6).

3.4 WHO's entirely new pandemic 'treaty' the new WHO CA+ which is a "Proposal for negotiating text of the WHO Pandemic Agreement".

More details on the four Treaties, are set out in **Schedule 2** to this letter.

4. What we seek from the office of the Attorney General on or before **24 November 2023** (bearing in mind the other dates and deadlines referenced in this letter):

4.1 Acknowledge receipt of this letter and confirm whether:

a) You and your office are aware of the four Treaties; and whether

b) You are considering how they will impact on the laws of New Zealand, including Treaty of Waitangi obligations, as well as all international instruments we are a party to.

4.2 Respond in writing to the following questions:

a) What preparatory work has your office undertaken in respect to the four Treaties, which have the potential to adversely impact on the human rights of New Zealanders?

b) If New Zealand were to tacitly accept the Treaties, what will be the effect on the operation of New Zealand sovereignty, domestic laws, international law, human rights and Treaty of Waitangi obligations?

4.3 Take the following steps:

a) Issue a direction to Cabinet to consider the Article 59 IHRAs as against the 307 IHRAs, the WHO CA+ and the UN PPPR Declaration. If there is insufficient time for Cabinet to consider these before the 1 December 2023 date for rejection or reservation, then reject or reserve New Zealand's position on the Article 59 IHRAs until it has had time to consider these. The assessed legal ramifications are summarised in the article attached as **Schedule 3** to this letter.

b) Inform the new government of the four Treaty documents, the directive you have issued at 4.3a) immediately above, and that you are considering the legitimate concerns raised in this letter.

5. We have prepared the following information set out in the schedules here to assist you and your office.

6. Further, we have sent a similar letter to the Human Rights Commissioner, **attached** here for your information.

We would be more than willing to meet with your office, otherwise and in the meantime we look forward to hearing from you as soon as possible.

Yours sincerely
For and on behalf of The Delegation To Wellington:

Katie Ashby-Koppens
Qualified Barrister and Solicitor of High Court of New Zealand

The Delegation To Wellington:
Dr Simon Thornley, Faculty of Medical and Health Sciences, Epidemiology and Biostatistics, University of Auckland
Martin Lally (Director, and former Associate Professor in Finance at Victoria University of Wellington)
Dr Alison Goodwin (President, New Zealand Medical Professionals' Society)
Dr Anne O'Rielly (Vice-President, New Zealand Medical Professionals' Society)
Dr Cindy de Villiers (New Zealand Doctors Speaking Out with Science)
Aku Huia Kaimanawa (Midwives Collective)

Jodie Brunning (MA Sociology, Physicians and Scientists for Global Responsibility (PSGR.org))
Katie Ashby-Koppens (Qualified Barrister and Solicitor of New Zealand)
Keri Molloy (Journalist)
Lynda Wharton (The Health Forum NZ)

Schedule 1 – Further comments on the recent public health response to the Covid-19 pandemic from a public law perspective

1. Fairness is a guiding principle of public law in New Zealand. However, the binding nature of the Amendments may result in the taking of arbitrary power that is antithetical to a constitutional monarchy. Law must conform to minimum standards of justice. Another word for fairness – is natural justice. The rule of law is based on the reconciling of state power with personal autonomy and liberty – and it's based on the factual setting in which law or policy is engaged. A pandemic will differ in the health impact by country, by age, by socio-economic status, and by health status.

2. The COVID-19 pandemic response saw a jettisoning of traditional public health principles that would be engaged in the management of pandemics. These are relevant to the IHRA amendment processes as the processes and policies that were implemented for COVID-19 serves as a precedent for future events.

3. The 2009 version of the WHO's Pandemic Alert Phases removed an association with severe risk. This enabled COVID-19 to be declared a pandemic without the majority of the population being at risk of hospitalisation and death. A high-risk event was not distinguished from an event of mild disease. (Abeysinghe 2013).

4. Fundamental principles that guide public health management were strangely ignored during the COVID-19 pandemic. Public health concerns the weighting of costs and benefits, and it is necessarily a local endeavour as particular sub-populations will be more or less at risk from different interventions. For example, the 2019 recommendations of pandemic influenza management strongly advised against measures such as border closures, or quarantine or restriction of healthy people. In place, modelling was used which also ignored known facts, such as the potential for natural immunity to stem infectivity and the potential for new viral variants to be more transmissible but less harmful.

5. The IHRA's are taken at a time when a decline in country-based core funding to the WHO has occurred, diverting the organization from its traditional public health funds. In 2021-2022 $6.4 billion of just under $8 billion in expenditure was due to earmarked funds. There has been a concurrent growth of international bodies parallel to the WHO whose focus is not on traditional public health activities, but on technologies.(Bell 2023) Cross-talk and funding between these organisations result in donor influence that may be stronger than the influence of individual member nations.

Schedule 2 – Background and further information and documents pertaining to the UN and WHO New and Amended Pandemic Treaties

1. UN's PPPR Declaration

The **UN's PPPR Declaration** was only tentatively adopted by the President of the General Assembly at the UN High-Level Meeting on 20 September 2023 after eleven (11) nations raised concerns about the lack of 'true and meaningful' engagement in the negotiations of the declaration and opposing the attempt to adopt the declaration at a high level meeting, instead of the full assembly, which is required by the relevant resolution.

Amongst other things, the UN PPPR Declaration identifies the requirement for US$30 billion for pandemic preparedness. By way of comparison, the WHO's current 2 yearly budget is US$11 billion.

The UN PPPR Declaration also sets out the requirement for any amendments to the 2005 International Health Regulations (**IHRs**) and the creation of a new Pandemic Treaty (the **WHO CA+**) by the Seventy-seventh World Health Assembly scheduled for the end of May 2024 (OP44 UN PPPR Declaration) and also confirmed in the WHO Decision WHA75(9).

2. The WHO's proposed amendments to the 2005 International Health Regulations (IHRAs) - are in two parts (2.1 and 2.2):

2.1 **Article 59 IHRAs** - This treaty proposes reducing the timing for rejection or implementation for any future proposed IHRAs (from 18 to 10 months, and 24 to 12 months respectively).

The Article 59 IHRAs were adopted by the WHA on 27 May 2022 – pursuant to Article 59 of IHRs the there is 18 months to expressly reject or reserve these proposed amendments by **1 December 2023**, otherwise the timeframes will become much shorter for assessment, rejection and implementation of any future amendments, relevantly the 307 IHRAs described in 2.2 immediately below. We also expand upon the Article 59 IHRAs in paragraph 3 of this schedule.

2.2 **307 IHRAs** are being worked on by the IHR Working Group at present. The 307 IHRAs propose significant changes to the 2005 IHRs including:

a) changing standing recommendations from non-binding to binding (Article 1);

b) changing the Scope and Purpose from one where the WHO advises on actual 'public health risk[s]' to the WHO giving binding directives on "all risks with a potential to impact public health" – ie not just pandemics, and could include climate events (Articles 1 and 2);

c) removing the Principle implementation of the Regulations from one focussed on the "full respect for dignity, human rights and fundamental freedoms of persons" to one "based on the principles of equity, inclusivity, coherence and in the common but differentiated responsibilities of the State Parties, taking into consideration their social and economic development" (Article 3);

d) requiring significant changes to our domestic legislation (eg Articles 5 and 55).

This is by no way a complete list. Further examples and analysis of the provisions are available here.

Pursuant to Article 55 of the IHRs, the text of any amendments is to be provided at least four months before the World Health Assembly meets so as to give the member states sufficient time to consider before they meet to vote on the adoption of the amendments (or otherwise). That is, the 307 IHRAs are to be submitted to the Director General of the WHO by mid-January 2024 for anticipated adoption at the Seventy-seventh WHA at the end of May 2024 as per the UN PPPR Declaration (OP44) and also confirmed in the relevant WHO Decision WHA75(9).

At the 2-6 October 2023 meeting of the Working Group of the IHRAs, the Working Group indicated it will not be able to meet the January 2024 delivery date (of mid January 2024) and has sought advice exempting the Working Group from complying with this timeframe and obligations under Article 55. Advice supplied by Stephen Solomon (WHO Secretariat legal counsel) at 27:00 or transcribed in **Schedule 3** for your convenience has set out an approach that would allow them to continue to work on the IHRAs up until the Seventy-seventh World Health Assembly.

Note this purported legal advice is not only wrong, it is in flagrant disregard and contravention of the Regulations themselves and the WHO Decision WHA75(9) which clearly set out that Article 55 of the IHRs applied to the IHRAs.

If the Working Group will not have the text of the 307 IHRAs finalised and available four months in advance of the Seventy-seventh meeting of the World Health Assembly, then there is no way New Zealand can reasonable acquiesce to shorter timeframes proposed under the Article 59 IHRAs.

2.3 The WHO's drafting of an entirely new **WHO CA+** is currently being worked on by the Intergovernmental Negotiating Body.

The WHO CA+ is it is a "Proposal for negotiating text of the WHO Pandemic Agreement", ie its an agreement to agree, or a heads of agreement – it is not actually a Treaty which New Zealand can review and draw conclusions from as to its suitability for New Zealand.

The WHO CA+ also sets out significant new requirements under what might best be considered a trade agreement for pharmaceutical products and medical and surveillance technology.

The WHO CA+ is also anticipated to be adopted at the Seventy-seventh WHA at the end of May 2024 as per the UN PPPR Declaration (OP44).

3. Article 59 IHRAs – future timeframes drastically reduced unless the Article 59 IHRAs expressly rejected

Current status of the Article 59 IHRAs:

On 19 October 2023, the Ministry of Health proactively released Cabinet material and briefings: Minor Amendments to the International Health Regulations 2005 Approval for Binding Action ministerial decision-making documents: which proposes New Zealand be bound to the minor administrative amendments proposed in the Article 59 IHRAs, and that tacit agreement means no action needs to be taken (and the amendments will become binding)

We are concerned that Cabinet only considered the Article 59 IHRAs on their own, without reference to any of the other three Treaty documents (two of which we appreciate are currently being worked on, but are all at stages of significant advancement, so as to be informative to whether Cabinet tacitly agrees to the shortened timeframes).

Further, we note Cabinet's dismissed the Te Aka Whai Ora's (Maori Health Authority) concerns[2] about the shorter time frames under the Article 59 IHRAs on the basis that the Authority can start reviewing the 307 IHRAs in advance. However, that solution is not possible, given the extension the IHR Working Group has received to continue to negotiate the 307 IHRAs up until the date they will be considered by the Assembly for adoption.

[2] Cabinet Paper, Document 2, Page 4, paragraphs 21-23.

Why we are concerned with the Article 59 IHRAs:

The UN PPPR Declaration (OP44) states that the WHO CA+ is "an ambitious legally binding convention" adopted under "Article 19 of the Constitution of the World Health Organization"; and the Article 59 IHRAs and the 307 IHRAs are one of the "other initiatives to support the central endeavour". Where the Treaties' legally binding ambition are realised, New Zealand will have significantly reduced latitude in managing epidemic infections under WHO jurisdiction (which at this stage is no longer an actual "public health risk" but "all risks with a potential to impact public health" (see Article 2, 307 IHRAs)).

The Treaties are a culmination of the UN PPPR Declaration. The significant limitations on timeframes under the Article 59 IHRAs will constrain the time available for our government to properly consider, reject and/or implement (at least) future IHRAs (ie the 307 IHRAs). The shortened timeline will not provide sufficient time for fulsome consideration of the impact and breadth of the IHRAs by New Zealand. Nor will the compressed timeframe allow for proper consultation with New Zealanders in accordance with our democracy.

The question has to be – what is the rush, and also how and why does this benefit New Zealand?

These timeframes in the Article 59 IHRAs need to be expressly rejected as the proposed reductions in time means that New Zealand will only have 10 months to consider the significant legal ramifications on our domestic legislation that the 307 IHRAs will require. Additionally within a similar timeline, New Zealand needs to consider in parallel the WHO CA+ and its implications.

We reiterate the Te Aka Whai Ora's concerns with the reduction in timeframes proposed under Article 59 IHRAs as set out under section 3 immediately above.

Further, given the 307 IHRAs will continue to be negotiated up until the Seventy-seventh World Health Assembly in May 2024, then we strongly recommend that the Article 59 IHRs be rejected pursuant to Article 59 and 61, or at the least reservations made pursuant to Article 62 to allow opportunity to consider the impacts of the future IHRAs, such as the 307 IHRAs. The Working Group to the 307 IHRAs need more time, let's all give ourselves as much time available to review these wide sweeping reforms of international significance.

4. The legally binding aspects of the WHO's 307 IHRAs and the WHO CA+

There is a clear implication in the Treaties that if not actively responded to, New Zealand will have to amend vast arrays of its domestic legislation, to comply with very significant amendments to the 2005 IHRs and the new WHO CA+, such as the:

4.1 legally binding nature (Article 1 of the 307 IHRAs; paragraph OP44 of the WHO CA+);

4.2 express amendment to laws (Articles new 13A(3), 43, 44, and 45 of the 307 IHRAs);

4.3 implementation of new legislation to indemnify pharmaceutical companies and limit their liability with respect to vaccine injuries as well as establish "no-fault vaccine injury compensation mechanisms" (Article 15 WHO CA+).

These are by no means a complete list of the Articles or amendments that could impact New Zealand domestic laws as set out in the UN PPPR Declaration, 307 IHRAs and the WHO CA+.

5. The very real consequences of the legally binding aspects of the WHO's 307 IHRAs and the WHO CA+

When similar issues set out in this letter are raised, we are regularly reassured that:

> *"While the exact form of the instrument is yet to be determined, if Member States agree to proceed with a legally binding instrument (for example, a treaty) standard New Zealand treaty-making processes, including Cabinet approval and parliamentary treaty examination, will be required before New Zealand could become party to the treaty.*
>
> *New Zealand government representatives are participating in negotiations in both the INB and WHR. Any decision to become party to a new treaty will be decided by the government once negotiations are concluded and would be subject to New Zealand's treaty-making processes, including Cabinet approval, parliamentary treaty examination, and the passing of legislation if required."*

We appreciate and understand the position being advanced. However, the reassurances are, with respect, disingenuous. By acquiescing to the 307 IHRAs and/or becoming a party to the WHO CA+, New Zealand will be promising to implement what it has agreed to in those international instruments. By acquiescing

to the Article 59 IHRAs New Zealand will severely constrain the time able to be given to undertake its standard treaty-making process.

It is important to acknowledge that in giving those promises New Zealand is pledging to the UN and the WHO, as well as the international community, its intention to ratify and enshrine those instruments in our domestic law. It is also important to ask the question; what would be the consequences of our failure to do so?

Further, when making new laws, or amending existing ones, Parliament (both current and future) have a positive onus to take into account all international covenants, treaties and instruments New Zealand is a party to. If New Zealand is a party to the 307 IHRAs and the WHO CA+, could Parliament selectively choose to legislate the international instruments articles it has agreed to and ignore the remainder?

This is why these Treaties cause concern, and why these concerns cannot be dismissed.

The 2005 IHRs, to which New Zealand is already a party and which are legally binding, at Article 59, sub 3 makes clear, that:

> *"If **a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations** within the period set out in paragraph 2 of this Article, **that State shall submit** within the period specified in paragraph 1 of this Article **a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations for that State Party.**"* (emphasis added)

The words could not be more clear. If this is the case, then 10 months to consider any future IHRAs such as the 307 IHRAs, and a further 12 months to implement them, will be impossible and consequently could result in legitimate consequences such as geopolitical sanctions and other international pressures for failure to comply and/or implement. Alternatively the constrained time period might impel New Zealand to consideration under Urgency curtailing proper examination and public consultation and agreement.

6. New Zealand’s human rights

These Treaties shall also impact New Zealand's human rights policy agenda. Examples of those impacts have been outlined in the letter addressed to the Human Rights Commissioner (**attached**).

Schedule 3 – ARTICLE:

The rejection, or reservation, by our governments to the WHO's proposed Article 59 amendments to the International Health Regulations is not a big deal – it's a bigger deal if they don't!

The Article 59 IHRAs have to be reserved or rejected by every member state to ensure the WHO follows its own rules! It will also help the Working Group, who are struggling to meet the mid January 2024 delivery date.

The rejection or reservation is not a big deal, it will simply give the member state the time to which it is entitled, to consider the substantial amendments that are coming!

The Article 59 amendments to the International Health Regulations (IHRAs) need to be actively rejected or reserved by each of the 194 member states by 1 December 2023, otherwise silence is acceptance and the amendments become binding on every member state that doesn't actively reject or reserve.

The Article 59 IHRAs seem minor in nature, they reduce the time frames from 18 months to 10 months for any rejection of future amendments, and from 24 months to 12 months for any implementation.

They need to be rejected or reserved because the WHO is ignoring its own rules to ram through the proposed amendments to the International Health Regulations (IHRAs), which it hasn't been able to finalise even in the 20 months the Working Group has had available to do so.

Both the Australian and New Zealand governments consider the Article 59 IHRAs are minor in nature: nothing to see here – the UN and WHO's Pandemic Treaties are a good thing - in everyone's best interests, while refusing to engage with the substance of the other treaty documents: the UN's Pandemic Preparedness Declaration, the 307 amendments to the IHRs and the recently updated and circulated WHO CA+.

Ordinarily, those shorter timeframes proposed in the Article 59 IHRAs might not be a tough ask for any government to consider, especially when the IHRs have always meant that the WHO is an organisation that gave advice (ie the Regulations were non-binding). However, what is proposed in the other WHO Treaty documents is more than any government can reasonably consider in 10 months, let alone the current 18 months it has available to it under the IHRs. Further hampering the timeframe for any review of the Treaty documents, the Regulations will be BINDING on each member state who doesn't expressly reject or reserve them. The 18 month time frames are already ambitious, in 10 months they will be impossible for our governments to properly consider the ramifications on our domestic legislation and obligations.

The shorter time frames might also be ok if the WHO was complying with the timeframes set out in their own rules (Article 55, below) meaning that any amendments are completed and circulated 4 months in advance of it being adopted at the World Health Assembly. That 4 month rule gives member states the opportunity to consider any amendments prior to them being considered for adoption at the World Health Assembly (which only meet once a year).

The 307 IHRAs presently being worked up by the Working Group (of which NZ's own Dr Bloomfield is a Co-chair), are required to be finalised and presented to the Director General of the WHO by mid January 2024 if they are to be considered by the 194 member states in time for adoption at the Seventy-seventh World Health Assembly scheduled in May 2024 (in compliance with Article 55 and confirmed in the U.N.'s Pandemic Preparedness Declaration (see OP 44)).

However, at the last meeting of the Working Group of the IHRAs, the Working Group confirmed that the 307 IHRAs won't be finalised and ready to provide to the IHR Review Committee and Director General by mid January 2024 (in compliance with the 4 month rule).

Consequently, advice was sought by the Working Group, from the WHO's lawyer about how the Working Group could get around the 4 month rule and continue to work on the 307 IHRAs up until May 2024, when the World Health Assembly next convenes to consider adoption of the rules (PS adoption by the WHA is likely *a fait accompli*).

The WHO's lawyer had such advice to hand: the 4 month rule to have the 307 IHRAs finalised in time for the member states to consider, doesn't apply to the Working Group is a subdivision of the World Health Assembly.

Stephen Solomon (WHO Secretariat legal counsel) had this to say at 27:00:

> *Article 55 of the IHR, including this four month requirement, has never been applied to amendments submitted collectively by a sub-division of the Health Assembly, which is exactly what the WGIHR is.*
>
> *The WGIHR is a subdivision of the Health Assembly under rule 41 [40?] of the Rules of Procedure of the Health Assembly.*
>
> *Thus, there are no precedents to rely on with respect to the manner in which the four month requirement set out in Article 55 should be satisfied.*
>
> *That is to say, Article 55 has been applied to amendments proposed by a state party or by the Director-General, but never by a subdivision of the Health Assembly.*

Accordingly, an option for consideration by the Working Group, would be for the Director-General to communicate in January 2023 [2024?] the following documents to all states parties:

First, the proposed amendments as originally submitted by member states and already communicated by the Secretariat to all states parties by email, and

Second, the proposed amendments as they might be shown on the screen at the closure of WGIHR/6.

This approach would allow work to continue in the WGIHR, if necessary, up until the 77th Health Assembly itself, recognizing the importance of complementarity with the INB process which, as we know, is mandated to work up until the 77th WHA.

In addition to that, the Working Group may consider requesting the Secretariat to include, in the January communication from the Director-General, a clarification according to which the amendments from the final session of the WGIHR, which could be, conceivably, as late as May, 2024, if necessary, would allow these final results of the May, of such a session, to be formally submitted to the 77th World Health Assembly.

A note on this deadline of the 77th World Health Assembly. If the deadline is not met, the WGIHR would be expected to report to the Health Assembly in May 2024 that agreement could not be reached on the proposed amendments.

This deadline cannot be changed as it was set out in decision WHA75/9 [(Decision)].

This approach just outlined for your consideration would fulfill the four month requirement in its purpose as proscribed by Article 55 of the IHR, while at the same time allowing the Working Group to continue its consideration and negotiation of the proposed amendments, including possible modifications to the package that would be communicated to the States Parties.

Should this approach be considered satisfactory, the Working Group may wish to consider reflecting it in the report of this session of the WGIHR.

(emphasis added)

So the deadline in the Decision can't be changed, but the deadline specified in the Regulations can be?

Let's be clear, the order of precedence is that Regulations come before decisions, that is Decisions are much easier to amend than Regulations, unless of course you ignore the Regulations.

This is nothing but Double Dutch, legal contortionism at its best, and this is why:

The Article 55 of the Regulations on amendments to the IHRs state:

1. *Amendments to these Regulations may be proposed by any State Party or by the Director-General. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.*
2. *The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration.*
3. *Amendments to these Regulations adopted by the Health Assembly pursuant to this Article shall come into force for all States Parties on the same terms, and subject to the same rights and obligations, as provided for in Article 22 of the Constitution of WHO and Articles 59 to 64 of these Regulations.*

Applying the words of the Article 59, the 307 IHRAs are:

1. amendments to be proposed by the Director General – as per 2(e) of the Decision, which specified "*the IHR Review Committee submit its report to the Director-General no later than 15 January 2023, with the Director-General communicating it without delay to the WGIHR"*
   - therefore satisfying Regulation Article 55 sub 1;
2. the Director General is required to submit any proposed amendments four months before the Health Assembly at which it is proposed for consideration - therefore satisfying Regulation Article 55 sub 2;
3. if adopted by the World Health Assembly, then as per Regulation Article 55 sub 3, the 307 IHRAs come into force subject to the timeframe requirements for rejection or reservation – ie the Article 59 IHRAs – pretty circular isn't it!

But wait, you don't have to trust my opinion on this, the Decision actually refers to the Working Group complying with the Article 55 timeframe, see 2(f) of the Decision, which states:

> "*to request the WGIHR to establish a programme of work, consistent with decision EB150(3), and taking into consideration the report of the IHR Review Committee, to propose a package of targeted amendments, for consideration by the Seventy-seventh World Health Assembly, in accordance with Article 55 of the International Health Regulations (2005);"*

The WHO's lawyer is making things up in breach of both the Regulations and the Decision.

The Article 59 IHRAs simply reduce the time frames for a member state to reject and implement.

If the Working Group needs more time on the IHRAs then that can be granted by amending the

Decision, then it has to be done by member states rejecting the Article 59 IHRAs, which means the old rules or 18 months to consider any amendments remains in place.

All this rejection does is give a member state the time to which it is entitled under the Regulations, to consider fully the sweeping changes proposed in the 307 IHRAs and the WHO CA+.

Our governments can buy the time they need to review the Treaties on our behalf, and in our interests, by simply rejecting or reserving their positions on the Article 59 IHRs and await the 307 IHRAs, which the Working Group needs more time to finalise.

The other benefit to this is that the various commissions and inquiries can be finalised, the outcomes of which can be aspects that best inform our governments.

Katie Ashby-Koppens
Qualified Barrister and Solicitor of the
High Court of New Zealand
Lawyer, NSW

Katie has had the opportunity to present to the US and Australian governments on the UN and WHO Pandemic Treaties. Katie's particular focus is on the impacts and effects of these Treaty documents on the member states of US, AU and NZ and their citizens.

Annexure: attached letter to Human Rights Commission